
WOOD-RIDGE SCHOOL DISTRICT
(201) 933-6777

PHYSICIAN'S CERTIFICATION

EPI-PEN

I, _____, am a licensed physician in the State of _____.

I certify that my patient, _____, requires the administration of epinephrine for anaphylaxis. I hereby provide the following information.

Diagnosis: _____

Name of Medication

Form: _____

Dose: _____

Describe indications if medication is to be given as needed: _____

How soon can the medication be repeated? _____

Is child authorized to self administer? _____

Side effects: _____

Length of time the treatment is recommended:

Date: _____

Physician's Signature _____